VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

April 20, 2016

Ms. Deborah Lemery, Administrator
Pillsbury Manor - South
20 Harbor View Road
South Burlington, VT 05403-7850

Dear Ms. Lemery:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on March 23, 2016. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Sincerely,

Suzanne E. Leavitt RN, MS

Suzanne Leavitt, RN, MS
Assistant Division Director
Director State Survey Agency

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0149	A. BUILDING: _____ B. WING _____	C 03/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILLSBURY MANOR - SOUTH	20 HARBOR VIEW ROAD SOUTH BURLINGTON, VT 05403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site re-licensing survey and two self-report investigations were completed by the Division of Licensing and Protection from 3/21 through 3/23/16. Based on information gathered, the following regulatory violations were cited:	R100		
R146 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the nurse failed to instruct direct care staff regarding each resident's health care needs and failed to delegate tasks as appropriate for 1 of 8 sampled residents. For Resident #8, the findings include the following: 1. Per record review for Resident #8, the medical record identifies multiple changes that have occurred during the past four (4) months. Care plan updates are not consistently noted on the plan of care. The findings include the following: (a.) Dysphagia. Charge Nurse confirms on 3/23/16 at 10 AM that the resident no longer has problems swallowing or eating. (b) Resident Self-Medicates. Resident was found to be non-compliant with taking his/her own medications and the order was discontinued on 1/20/16. Resident is assisted by staff with all medication administration. (c) Resident is an elopement risk evidenced	R146	re R146; Care plan policy reviewed with all staff RN oversight to audit care plans monthly for changes. 4.15.16 Doc amnt 4.20.16 MB/BK	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elizabeth McCoy LPN, Administrator — TITLE — (X6) DATE: April 19, 2016

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R146	Continued From page 1 by multiple episodes of leaving the facility without staff notification, without signing out of the building and by multiple community members reporting falls that were witnessed,while walking down the hill. 11/17/15: Community member notified the facility that the resident had fallen x's 2 while walking down the hill unattended. 911 called. 12/21/15: One hour checks initiated. 1/27/16: Community member witnessed resident crossing the street and notified facility staff. 3/23/16: Resident left the facility and was later located at the Good Will store on the Williston Road after taking the bus unattended and/or notifying staff that s/he was leaving the premises.. (d) Falls and change in mental status are not addressed on the care plan as active problems that have been identified in the nurses notes. Per interview with the manger on 3/23/16 at approximately 10:30 AM confirmation is made that the care plan does not reflect the resident's current status.	R146		
R160 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.a Each residential care home must have written policies and procedures describing the home's medication management practices. The	R160		

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R160	Continued From page 2 policies must cover at least the following: (1) Level III homes must provide medication management under the supervision of a licensed nurse. Level IV homes must determine whether the home is capable of and willing to provide assistance with medications and/or administration of medications as provided under these regulations. Residents must be fully informed of the home's policy prior to admission. (2) Who provides the professional nursing delegation if the home administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the home. (3) Qualifications of the staff who will be managing medications or administering medications and the home's process for nursing supervision of the staff. (4) How medications shall be obtained for residents including choices of pharmacies. (5) Procedures for documentation of medication administration. (6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal. (7) Procedures for monitoring side effects of psychoactive medications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to monitor for side effects of psychoactive medications for 1 of 8 sampled residents. For Resident #3 the findings include the following: Per record review Resident #3 has hallucinations and delusions evidenced by comments made by the resident that s/he is seeing kittens, cats and	R160	R 160; reviewed psychoactive med flow sheet policy posted for staff (including AIMS) RN oversight responsible for maintaining records quarterly + PRN POC compl 4.20.16 MB RN	4.15.16

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R160	Continued From page 3 children in her presence. Per physician's order dated 2/3/13, requests that the resident is to receive Seroquel 12.5 milligrams (mg) by mouth (po) every night at hour of sleep. Seroquel is an antipsychotic medication. The facility is responsible to monitor the resident for abnormal involuntary movements and utilizes an Abnormal Involuntary Movement Scale (AIMS) to evaluate for those side effects from antipsychotic medications. Per facility policy dated 2/7/13 titled "Psychoactive Medication Flow Sheets", protocol dictates if the resident is on an anti-psychotic medication then the AIMS review will be completed quarterly. Per medical record review, Resident #3 had an AIMS evaluation completed on 3/31/15. The facility policy is to evaluate the resident quarterly, therefor the resident has not been monitored for side effects of antipsychotic medication for 12 months. Confirmation was made by the Registered Nurse on 3/22/16 at 8:20 AM.	R160	R161 Employee was re-educated on policy on date of Survey & 3.29.16 received 1:1 training again c RN oversight on 4.15.16	3.29.16 4.15.16
R161 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.b The manager of the home is responsible for ensuring that all medications are handled according to the home's policies and that designated staff are fully trained in the policies and procedures. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview, the manager of the facility failed to	R161	Document 4.20.16 MB/SL	

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R161	Continued From page 4 ensure that all medications are handled according to the home's policy on infection control during a medication administration observation for 7 residents. The findings include the following: Per observation on 3/21/16, during the noon medication pass with an approved Medication Technician, seven (7) residents were assisted with their noon hour medications. The technician did not wash his/her hands or sanitize his/her hands after coming in direct contact with each resident. Per facility policy dated 1/23/13 titled "Infection Control Policies" identifies that hand washing is to be performed between all residents when direct care has been performed. At the completion of the medication pass at approximately 12:30 PM and after 12 medications had been delivered, the technician confirmed that s/he had forgotten to wash or sanitize his/her hands in-between residents. S/he demonstrated that the hand sanitizer was on the medication cart for her/his use. (see 169)	R161		
R169 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.e Staff responsible for assisting residents with medications must receive training in the following areas before assisting with any medications from the licensed nurse: (1) The basis for determining "assistance"	R169		

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R169	Continued From page 5 versus "administration". (2) The resident's right to direct the resident's own care, including the right to refuse medications. (3) Proper techniques for assisting with medications, including hand washing and checking the medication for the right resident, medication, dose, time, route. (4) Signs, symptoms and likely side effects to be aware of for any medication a resident receives. (5) The home's policies and procedures for assistance with medications. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview the facility failed to ensure that medications were provided in a manner that utilized the facility infection control practices during medication administration observed for 7 residents. The findings include the following: Per observation on 3/21/16, during the noon medication pass with an approved Medication Technician, seven (7) residents were assisted with their noon hour medications. The technician did not wash his/her hands or sanitizer his/her hands after coming in direct contact with each of the residents. Per facility policy dated 1/23/13 titled "Infection Control Policies" identifies that hand washing is to be performed between all residents when direct care has been performed. At the completion of the pass at approximately 12:30 PM and after 12 medications had been delivered, the technician confirmed that s/he had forgotten to wash or sanitize his/her hands	R169	R 169 Employee was disciplined for not following policy 3.29.16 reviewed Universal Precautions + infection control policy c̄ employee + RN oversight 1:1 handwashing session/teaching w/employee	3.29.16 4.15.16

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R169	Continued From page 6 in-between residents. S/he demonstrated that the hand sanitizer was on the medication cart for her/his use. (see 161)	R169		
R179 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on interview and employee file review, 2 of	R179	R179 reviewed Inservice Policy & follow administrator revising inservice record keeping Administrator IS responsible for adhering to regulation Per amt 4.20.16 ms/hl	4.19.16

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R179	Continued From page 7 5 employee have not met the requirement for 12 hours of training annually for each staff member providing direct care to the residents. The findings include the following: Per employee file review, employees have met the training topic requirements, but have not met the mandated twelve (12) hours of annual training. Evidence demonstrates the following: Employee #2 has a total of 1.9 hours of training from anniversary date 2/3/15. Employee #3 has a total of 4.16 hours of training from anniversary date 2/28/15. Per review of "Inservice Policy for Employees", identifies that employees will have 12 hours of in-service training as regulated by the State. Per interview with the manager, confirmation is made on 3/23/16 that the above information is accurate and facility policy was not followed.	R179		
R191 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.12 Records/Reports 5.12.c A home must file the following reports with the licensing agency: 5.12.c.(1) When a fire occurs in the home, regardless of size or damage, the licensing agency and the Department of Labor and Industry must be notified within twenty-four (24) hours. A written report must be submitted to both departments within seventy-two (72) hours. A copy of the report shall be kept on file.	R191		

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R191	Continued From page 8 5.12.c.(2) A written report of any accident or illness shall be placed in the resident's record. Any untimely deaths shall be reported and a record kept on file. 5.12.c. (3) A report of any unexplained absence of a resident from a home for more than 12 hours shall be reported to the police, legal representative and family, if any. The incident shall be reported to the licensing agency within twenty-four (24) hours of disappearance followed by a written report within seventy-two (72) hours, a copy of which shall be maintained. 5.12.c.(4) A written report of any breakdown or cessation to the home's physical plant's major services (plumbing, heat, water supply, etc.) or supplied service, which disrupts the normal course of operation. The licensee shall notify the licensing agency immediately whenever such an incident occurs. A copy of the report shall be sent to the licensing agency within seventy-two (72) hours. 5.12.c. (5) A written report of any reports or incidents of abuse, neglect or exploitation reported to the licensing agency. 5.12.c. (6) A written report of resident injury or death following the use of mechanical or chemical restraint. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to file a written report to the licensing agency, of an untimely death for 1 of 8 sampled residents. For resident #1 the findings include the following:	R191		

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R191	Continued From page 9 Per record review, nurses notes identify that on 7/5/15 at 3:16 AM, Resident #1 was found on the floor of his/her room and sustained a skin tear to the right forearm and complained of right arm pain. Per nurses notes dated 7/5/15 resident expired at 9:10 PM, seven (7) hours after the fall. Per facility policy titled "Unexpected or Untimely Death of a Resident" dated 2/4/13, identifies that when a resident dies unexpectedly or within forty eight (48) hours of a fall, staff are to notify the physician and report the death. Physician is to direct staff to notify the Medical Examiners (ME) Office if necessary. Nurses notes identify that the Hospice Registered Nurse (RN) made the decision that the ME's office did not need to be notified. Per internal investigation documentation dated 7/9/15 by the facility Administrator, Resident #1 was receiving Hospice services and actively dying. The Administrator acknowledged knowing the resident had fallen 7 hours earlier. The administrator reviewed regulatory requirements and reported the untimely death four (4) days late on 7/9/15. Per interview with the current Manger on 3/21/16 confirmation was made that the report of an untimely death for Resident #1 was late and facility protocol was not followed.	R191	R191 Current administrator reviewed policy & is aware of regulation. Administrator/RN oversight are responsible for reporting in the future	4.18.16
R299 SS=E	IX. PHYSICAL PLANT 9.10 Life Safety/Building Construction All homes shall meet all of the applicable fire safety and building requirements of the	R299	POC sent 4/20.16 MS/DA	

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R299	Continued From page 10 Department of Labor and Industry, Division of Fire Prevention. This REQUIREMENT is not met as evidenced by: Based on record review, observation and confirmed by staff interview the facility failed to have three (3) boilers inspected by a licensed certified boiler inspector, as indicated by the Vermont Fire and Building Safety Code 2012 (Section 6-Boiler and Pressure Vessel Inspection) within the the two (2) year required timeframe. The facility also failed to ensure that the elevator was inspected timely. The findings include the following: 1. Per observation during the environmental tour with the Director of Maintenance on 3/22/16 at approximately 12:30 PM, review of the 3 boilers located in the basement, indicate that the most recent inspection by a licensed boiler technician on each boiler is tagged as completed on 9/22/10. Per regulation, each boiler should be inspected every 2 years. The Director of Maintenance confirms during this tour, that the last inspection was completed on 9/22/10 as the three (3) tags indicate, which is 6 years ago. 2. Per observation during the environmental tour with the Director of Maintenance on 3/22/16 at approximately 12:30 PM, review of the elevator indicates that the license expired on 2/25/16. Per interview the director, confirmation is made that the elevator was inspected prior to the expiration date and was found to have an inoperable telephone. The work is in the process of being competed, however the license located	R299	R 299 Boiler Inspection is scheduled for 4/19/16 Director of Maintenance aware + responsible for all physical plant inspections 4.15.16 Elevator Inspection completed 3/23/16. 3.23.16 See attached boiler + elevator inspection tags Per email 4.20.16 MB	

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R299	Continued From page 11 in the elevator indicates the license expired on 2/25/16 and therefor is outdated. Per conversation with the Deputy Director of Division of Fire Safety on 3/25/16 at 10:30 AM, confirmation is made that the boilers and the elevator have not met applicable fire and safety codes and are in violation.	R299	R999 Executive Director communicated w/ licensing chief during survey in writing regarding change of administration 3.23.16	
R999 SS=C	MISCELLANEOUS 4.11 Transfer Prohibited: A license shall be issued only for the person(s) and premises named in the application and is not transferable or assignable. Based on observation of current Residential Care Home License, the facility has failed to notify the licensing agency of a change in management. The findings include the following: Per facility tour on 3/21/16 with the Manager, the facility license located at the reception desk, evidences the previous Administrator's name. Per interview with both the Manager and the facility Owner at approximately 11:45 AM, confirmation is made that the facility has failed to submit a letter to the listening agency for the request/review of the new manager who began her/his position on 2/22/16.	R999	Account 4.2016 mb/sm	

VERMONT DEPARTMENT OF PUBLIC SAFETY

DIVISION OF FIRE SAFETY

Office of the State Fire Marshal, State Fire Academy and State Haz-Mat Team

VERMONT

CERTIFICATE OF BOILER & PRESSURE VESSEL INSPECTION

VERMONT FIRE & BUILDING SAFETY CODE
BOILER/PV PROOF OF INSPECTION

INSP. NO. 115800/

4/19/16 — INSPECTION DATE
4/19/18 — EXP. DATE

VIOLATIONS
☐ YES ☑ NO ☐ CORRECTED
4/19/16 — DATE
KS — INITIALS

DIVISION OF FIRE SAFETY
VERMONT DEPT. OF PUBLIC SAFETY

☒ Boiler ☐ Pressure Vessel ☐ External ☐ Internal

Name:	Pillsbury Assoc. Inc				
s:	20 Harbor View Rd.				
) #:	29420		NB # :	405	
r:	NTI	Year:	2004	Object Type:	
	30	S/V- R/V Set Pressure:		30	
:	HSB	Inspector Name (Print):		Jeff Baker	
	949	Inspector Signature:		Jeff Baker	

REINSPECTIONS

PE: ING	DATE Mo/Day/Year	INSPECTOR NAME	VERMONT COMM. #	VIOLATIONS FOUND

Vermont Department of Public Safety

Division of Fire Safety

CONVEYANCE
CERTIFICATE OF OPERATION

VERMONT FIRE & BUILDING SAFETY CODE
CONVEYANCE PROOF OF INSPECTION
INSP. NO. 16- 2265
VIOLATIONS
☐ YES ☑ NO ☐ CORRECTED
2016
DIVISION OF FIRE SAFETY
VERMONT DEPT. OF PUBLIC SAFETY

Location: PILLSBURY MANOR SOUTH
State Site #: 17062 Conveyance #: VTEL-5307 Exp. Date: 11/25/2016
Maximum Capacity: 2100 Pounds Maximum Speed: 130 Ft. per minute
Inspector License #: ELI - 31

Commissioner: _____
Keith W. Flynn

* Report any incident involving personal injury to 802-479-7561.
* The permit shall be clearly displayed on or in each conveyance.